

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

08841

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08852  
Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Washington</b> b. COUNTY <b>D.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palmers</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b>			
c. LENGTH OF STAY IN 1b <b>2 Weeks</b>				d. STREET ADDRESS <b>1720 15th N.W.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James David Campbell</b>				4. DATE OF DEATH <b>August 18 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 29, 1884</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Schoolteacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>D.C. School</b>		11. BIRTHPLACE (State or foreign country) <b>D.C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Josephine C. Campbell</b>		Address <b>1720 15th N.W. Washington, D.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>NONE</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>W.D. Boyd</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>William D. Boyd</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>8/13/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/22/1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		22d. LOCATION (City, town, or county) (State) <b>Washington D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McGuire Funeral Service</b>				24a. REC'D BY REGISTRAR <b>8/20/57</b>			
24b. REGISTRAR'S SIGNATURE <b>Aland J. Houser</b>							

RECEIVED  
AUG 21 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08842

## CERTIFICATE OF DEATH

08853

Reg. Dist. No. 221

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Inigoes</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Marys Hospital</u>				d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Barbara Magdelyn Carroll</u>				4. DATE OF DEATH Month Day Year <u>August 31 1957</u>			
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1878</u>		9. AGE (In years last birthday) <u>79</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peacock</u>				14. MOTHER'S MAIDEN NAME <u>Cecelia Raley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>James W. Carroll- Dameron, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary embolism</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>12 hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug 31, 1957</u> , to <u>Aug 31, 1957</u> , that I last saw the deceased alive on <u>Aug 31, 1957</u> , and that death occurred at <u>3 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Great Mills, Maryland</u> <u>9/1/57</u>							
ACTUAL SIGNATURE <u>PJB</u>		M.D. <u>Great Mills, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>P.J. Bean, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/2/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. James Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>St. Marys City, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>Sept 1, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

# CERTIFICATE OF DEATH

BUREAU V. 2

SEP 4 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08843

CERTIFICATE OF DEATH

Reg. Dist. No.

08854-2

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ST. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Walter</b> Last <b>Cheseldine</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 4, 1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months <b>30</b>	IF UNDER 24 HRS. Hours <b>30</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Richard Cheseldine</b>				14. MOTHER'S MAIDEN NAME <b>Anna Turner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or no; if yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-38-3581</b>		17. INFORMANT <b>Mrs Elsie Cheseldine</b> Address <b>Avenue, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour <b>6</b> a. m. <b>8</b> p. m. Month <b>8</b> Day <b>11</b> Year <b>1957</b>			20d. INJURY OCCURRED White <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <b>Aug 8, 1957</b> to <b>Aug 11, 1957</b> , that I last saw the deceased alive on <b>Aug 8, 1957</b> , and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Leon Berube</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Leon Berube M.D. Mechanicsville, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>All Saints</b>		22d. LOCATION (City, town, or county) _____ (State) _____ <b>Oakley, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b> Address <b>Leonardtwn, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>8/13/57</b>		24b. REGISTRAR'S SIGNATURE <b>Gleason D. Houser</b>	



CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		10/15/1912	
Place of Birth		Cause of Death		Date of Death		Time of Death	
Baltimore, Md.		Heart Disease		10/20/1957		10:30 AM	
Occupation		Physician's Name		Hospital or Place of Death		Manner of Death	
Teacher		Dr. J. Smith		St. Mary's Hospital		Natural	
Signature of Physician		Signature of Registrar		Signature of Informant		Signature of Deceased	
[Signature]		[Signature]		[Signature]		[Signature]	
Printed Name of Physician		Printed Name of Registrar		Printed Name of Informant		Printed Name of Deceased	
John Doe		John Doe		John Doe		John Doe	
Title of Physician		Title of Registrar		Title of Informant		Title of Deceased	
M.D.		Registrar		Informant		Deceased	
Address of Physician		Address of Registrar		Address of Informant		Address of Deceased	
123 Main St.		456 Main St.		789 Main St.		101 Main St.	
City		City		City		City	
Baltimore		Baltimore		Baltimore		Baltimore	
State		State		State		State	
Md.		Md.		Md.		Md.	
County		County		County		County	
Baltimore		Baltimore		Baltimore		Baltimore	
Zip		Zip		Zip		Zip	
21201		21201		21201		21201	

RECEIVED  
AUG 14 1957  
BUREAU V. 3

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18											
Items #3, 14, 13, & 17 - See birth cert.											
08844											
08857											
Reg. Dist. No. 257											
1. PLACE OF DEATH a. COUNTY <b>Saint Mary's</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Mary's</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>			c. LENGTH OF STAY IN 1b <b>16 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Great Mills</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Irwin</b> Last <b>Edgston</b>					4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 57</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 25, 1957</b>		9. AGE (In years last birthday) yrs. <b>22</b> Months <b>22</b> Days <b>22</b> Hours <b>22</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Leonardtwn, Md.</b>			
13. FATHER'S NAME <b>George Edgston Edison</b>					14. MOTHER'S MAIDEN NAME <b>Marie Edgston Briscoe</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT <b>Edison</b> Address <b>Marie Briscoe Edgston Great Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Enterocolitis</b> <b>7640</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Hour a. ft. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <b>Aug 14, 1957</b> to <b>Aug 16, 1957</b> that I last saw the deceased alive on <b>Aug 16, 1957</b> , and that death occurred at <b>7 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Aug 17/57</b>											
ACTUAL SIGNATURE <b>P.J. Bean M.D.</b>					GREAT MILLS, MARYLAND						
PHYSICIAN'S NAME (Type) <b>P.J. Bean M.D.</b>					GREAT MILLS, MARYLAND						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			22b. DATE THEREOF <b>8/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Face</b>			22d. LOCATION (City, town, or county) (State) <b>Great Mills Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.C. Mattingley</b>					ADDRESS <b>Leonardtwn, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>Aug 17/57</b>		24b. REGISTRAR'S SIGNATURE <b>Local Registrar</b>		

2078244XV5

CERTIFICATE OF DEATH

MR. [Name] [Age] [Sex] [Race]  
[Address]  
[City] [State] [Zip]  
[Date of Birth] [Date of Death]  
[Cause of Death]  
[Place of Death]  
[Signature]  
[Date]

BUREAU V. 1

AUG 20 1957

RECEIVED

STATE DEPARTMENT OF HEALTH  
BALTIMORE, MARYLAND  
[Signature]  
[Date]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08845

## CERTIFICATE OF DEATH

Reg. Dist. No.

088582

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>X2</b> <b>Drayden</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hosp.</b>		d. STREET ADDRESS <b>1 Rural</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>C.</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 11, 1903</b>
9. AGE (In years last birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>State Road Comm.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Green</b>		14. MOTHER'S MAIDEN NAME <b>Violet C. Mason</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Agnes E. Green - Drayden, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CA of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/3</b> , 19 <b>57</b> , to <b>8/3</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/3/57</b> , 19 <b>57</b> , and that death occurred at <b>4:30 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>William D. Boyd</b> M.D.		ADDRESS (Street, city or town, state) <b>Leonardtown, Md.</b>	
DATE SIGNED <b>8/5/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/6/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Georges Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Maryland</b>		24a. REC'D BY REGISTRAR <b>8/5/57</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles D. Hanger</b>			

# STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITALS CERTIFICATE OF DEATH

BUREAU V. S.

AUG 6 1957

RECEIVED

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 attached, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
08846  
CERTIFICATE OF DEATH

Reg. Dist. No.

08857  
282

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>		c. LENGTH OF STAY IN 1b <b>x 2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Daniel Phillip Johnson</b>		4. DATE OF DEATH Month Day Year <b>August 17 19 57</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10 / 13 / 1866</b>
9. AGE (In years last birthday) <b>90</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Hilary Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Maria Thompson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>-----</b>	
17. INFORMANT <b>Mrs. M.H. Johnson- Leonardtown, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arterio Sclerotic CV disease</b> <b>402.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> Not at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 1950</b> to <b>Aug 1957</b> , that I last saw the deceased alive on <b>Aug 17 1957</b> , and that death occurred at <b>1057 M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>J. Roy Guyther</b>		ADDRESS (Street, city or town, state) <b>Mechanicsville, Md.</b>	
PHYSICIAN'S NAME (Type) <b>J. Roy Guyther, M.D.</b>		DATE SIGNED <b>Mechanicsville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtown, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson</b>		ADDRESS <b>- Leonardtown, Md.</b>	
24a. REC'D BY REGISTRAR <b>8/20/57</b>		24b. REGISTRAR'S SIGNATURE <b>Alan D. Guyser</b>	

RECEIVED  
AUG 22 1957  
BUREAU Y. B.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forw: to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08847

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08858

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>USNAS, Patuxent River</b> c. LENGTH OF STAY IN lb <b>1 month</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Air Station</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Texas</b> b. COUNTY <b>Dallas</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Grand Prairie</b> d. STREET ADDRESS <b>1314 Burleson</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jack</b> Middle <b>Earl</b> Last <b>LUCAS</b>		4. DATE OF DEATH Month <b>August</b> Day <b>1</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 8, 1930</b>
9. AGE (In years last birthday) <b>26</b> yrs.		IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min. <b>26</b>	IF UNDER 24 HRS. Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min. <b>26</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Aircraft Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chance Vought Inc</b>	
11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Colemar Lucas</b>		14. MOTHER'S MAIDEN NAME <b>Constance Mae McCoy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>1948-1952</b>		16. SOCIAL SECURITY NO. <b>463 30 0203</b>	
17. INFORMANT <b>(Wife) Marie Lucas</b>		Address <b>Lexington Park, 368 Chinlee, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries, Multiple, Extreme</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>864x</b> DUE TO (c) <b>Immediately</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediately</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Working under parked aircraft which fell on him.</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:28 p.m. August 1, 1957</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>U.S. Naval Air Station, Aircraft Hangar</b>		20f. City <b>St. Mary's</b> County <b>St. Mary's</b> State <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Wm. D. BOYD</b> EXAMINER'S NAME (Type) <b>R. D. NAUMAN, CDR MC USN</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <b>August 1, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/4/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Calvary</b>		22d. LOCATION (City, town, or county) (State) <b>Marlin, Falls Co. Texas</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Adams Funeral Home</b>		ADDRESS <b>Marlin, Texas</b>	
24a. REC'D BY REGISTRAR <b>8/2/57</b>		24b. REGISTRAR'S SIGNATURE <b>Glenn D. Houser</b>	



BUREAU V

AUG 5 1957

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may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08859

08848

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>			c. LENGTH OF STAY IN 1b <b>12 hrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Loveville</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Baby</b> Middle <b>Girl</b> Last <b>Morgan</b>				4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 4, 1957</b>	
9. AGE (In years last birthday) yrs. <b>12</b>		IF UNDER 1 YEAR Months <b>12</b> Days <b>12</b> Hours <b>12</b> Min <b>12</b>		IF UNDER 24 HRS yrs. <b>12</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Mary R. Morgan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Henry W. Morgan Loveville, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intra cranial Bleeding</b> DUE TO <b>Premature Birth</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> (c) <b>-----</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Morganza, Maryland</b>				20g. (County) (State)			
21. I certify that I attended the deceased from <b>Aug 4, 1957</b> , to <b>Aug 5, 1957</b> , that I last saw the deceased alive on <b>Aug 5, 1957</b> , and that death occurred at <b>4:30 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Roy Guyther</b>				M.D. <b>Free Hamilton</b>			
PHYSICIAN'S NAME (Type) <b>J. Roy Guyther M.D.</b>				<b>Mechanicsville, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 6, 57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph</b>		22d. LOCATION (City, town, or county) (State) <b>Morganza, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>8/5/57</b>		24b. REGISTRAR'S SIGNATURE	

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BUREAU V. S.

AUG 9 1957

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08849

CERTIFICATE OF DEATH

Reg. Dist. No.

08860  
282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bushwood</b>				c. LENGTH OF STAY IN 1b <b>2 months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Forest Heights X2</b>			
d. STREET ADDRESS <b>120 Fox Way</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daisy</b> Middle <b>Maria</b> Last <b>Oliver</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1957</b>			
5 SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1882</b>		9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>John Bernard Ellis</b>			
14. MOTHER'S MAIDEN NAME <b>Rebecca Cheseldine</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>			
16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>Joseph Aloysius Oliver</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic CV disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Mechanicsville, Md.</b>				20g. (County) <b>Mechanicsville, Md.</b>		20h. (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>Aug 16</b> , 1957, to <b>Aug 16</b> , 1957, that I last saw the deceased alive on <b>Aug 16</b> , 1957, and that death occurred at <b>10:20 PM</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. Roy Guyther</b>				M.D. <b>Mechanicsville, Md.</b>			
PERSON'S NAME (Type) <b>J. Roy Guyther M.D.</b>				DATE SIGNED <b>8/17/57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln</b>		22d. LOCATION (City, town, or county) (State) <b>3201 Bladensburg Rd. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Himothy Hanlon</b>				ADDRESS <b>3831 Georgia Ave. N.W.</b>		24a. REC'D BY REGISTRAR DATE <b>8/20/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>W. L. G. G. G.</b>	

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JG 21 1957

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08850

## CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>2 weeks</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				d. STREET ADDRESS <b>1</b>			
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>M.</b> Last <b>Smith</b>				4. DATE OF DEATH Month <b>August</b> Day <b>7</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 12, 1888</b>	9. AGE (In years last birthday) <b>69</b> yrs	IF UNDER 1 YEAR Months <b>26</b> Days <b>26</b> Hours <b>26</b> Min	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Boys School</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Louis Jefferson Smith</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Mrs Lue Dailey Leonardtown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Nephritis</b> DUE TO <b>Coronary of Lovers</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary of Lovers</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Jan 2<sup>nd</sup></b> , 19 <b>57</b> , to <b>Aug 7<sup>th</sup></b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Aug 7<sup>th</sup></b> , 19 <b>57</b> , and that death occurred at <b>5 P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Leonardtown Maryland</b> DATE SIGNED <b>Charles Greenwell</b>							
ACTUAL SIGNATURE <b>Charles Greenwell</b> M.D.				PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b> <b>Leonardtown, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/10/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Marks</b>		22d. LOCATION (City, town, or county) (State) <b>Valley Lee, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>8/9/57</b>		24b. REGISTRAR'S SIGNATURE <b>W. Clarke Mattingley</b>	

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AUG 12 1957

BUREAU K. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08851

## CERTIFICATE OF DEATH

Reg. Dist. No.

08862  
282

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X/ Rural Hollywood</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Mary's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Ernest</b> Last <b>Somerville</b>				4. DATE OF DEATH Month <b>August</b> Day <b>15</b> Year <b>19 57</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 27, 1946</b>	
9. AGE (In years last birthday) <b>11</b> yrs.		IF UNDER 1 YEAR Months <b>2</b> Days <b>19</b> Hours <b></b> Min. <b></b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Mitchell Somerville</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Stevens</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mitchell Somerville</b> Address <b>Hollywood, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Enteritis</b> <b>571.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Toxemia due to enteritis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>a. 11</b> Month <b>19</b> Day <b>19</b> Year <b>1957</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>August 27, 1956</b> to <b>August 15, 1957</b> , that I last saw the deceased alive on <b>August 15, 1957</b> , and that death occurred at <b>3: P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Chas. Greenwell</b>				ADDRESS (Street, city or town, state) <b>Leonardtwn Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Charles Greenwell M.D.</b>				DATE SIGNED <b>Leonardtwn, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/17/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. John's</b>		22d. LOCATION (City, town, or county) (State) <b>Hollywood, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Clarke Mattingley</b>				ADDRESS <b>Leonardtwn, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>8/16/57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Alfred D. Lousier</b>			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex	
John Doe		35		Male	
Date of Death		Place of Death		Cause of Death	
Aug 15, 1957		St. Mary's Hospital		Heart Disease	
Time of Death		Physician		Manner of Death	
10:00 AM		Dr. J. Smith		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	

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Name of Hospital		Name of Physician	
St. Mary's Hospital		Dr. J. Smith	
Name of Registrar		Name of Coroner	
[Signature]		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08852

## CERTIFICATE OF DEATH

08863

Reg. Dist. No.

282

1. PLACE OF DEATH a. COUNTY <b>St. Marys</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Marys</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Leonardtwn</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hollywood</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>St. Marys Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Wellington</b> Last <b>Wathen, Sr.</b>				4. DATE OF DEATH Month <b>August</b> Day <b>6</b> Year <b>1957</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/30/1884</b>		9. AGE (In years last birthday) yrs. <b>72</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm owner</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John H. Wathen</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Joy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. -----		17. INFORMANT <b>John W. Wathen, Jr. Lexington Park, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cancer of Stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetic</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 5</b> , 19 <b>57</b> , to <b>August 6</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>August 6</b> , 19 <b>57</b> , and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Charles Greenwell M.D. Leonardtown Md. 8/8/57</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>Charles Greenwell, M.D. Leonardtown, Md. 8/8/57</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/9/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Aloysius Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Leonardtwn, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>P.B. Robinson - Leonardtown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>8/8/57</b>		24b. REGISTRAR'S SIGNATURE <b>William R. Hanner</b>	



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